Peers in the Behavioral Health Workforce

Summary of Panel Presentation to Catchment Area Councils of Southwestern CT ▪ February 2018

This report summarizes the presentation by members of the Southwest CT Mental Health System (SWCMHS) and CT Counseling Centers at the February 2018 Catchment Area Councils joint meeting. (Presenters from Continuum and Norwalk Hospital were unable to attend the rescheduled meeting following a snow date.) The summary incorporates comments made by consumers and providers in the audience, including people working as or with peers at CCAR, LifeBridge, FS Dubois, and the Bridgeport CCT team.

L-R: Joanne Butler, Julie Nightingale, Barbara-Ann Tuozzolo (SWCMHS); Vered Brandman (CAC 1&2 Chair); Margaret Watt (Southwest Regional Mental Health Board Director); Denique Weidema-Lewis (CAC 3&4 Chair); Kurt Kemmling & Matt Guzzetti (CT Counseling)

Purpose:

To showcase different ways trained "peers"—people with lived experience with mental illness and/or substance use disorders, also known as people in recovery—are incorporated into different behavioral health settings; discuss the benefits of involving peers as part of treatment; and identify next steps.

Ways Peers are Used in Behavioral Health Settings:

Example: Southwest CT Mental Health System (SWCMHS)

SWCMHS is the regional branch of the state Department of Mental Health and Addiction Services (DMHAS). For the past 5 years, SWCMHS has had a **stipend program** that allows consumers to rise up through the ranks to become **Recovery Support Specialists (RSS's)**. RSS's work with a caseload of 10-12 people, providing skills-building, activities of daily living, and social skills and making them aware of other program options.

4 types of peer programs fall under the Work Training Program:

- **People Utilizing Skills for Healing (PUSH) Program**, which uses peers to run a social rehabilitation program that helps people both in the community and at the center. PUSH is at the FS Dubois Center in Stamford. The RSS's co-facilitate weekly groups (IDDT, art therapy, relapse prevention). Clients usually participate in 3 groups per week.
- **Greeters,** who welcome and direct people at the FS Dubois Center in Stamford and at the Greater Bridgeport Mental Health Center. Greeters advise visitors and consumers about programs and activities.
- **Pros**, who work on the Inpatient Unit at Greater Bridgeport.

- **Warmline operators,** who are trained to answer the warmline and provide telephone support to shut-ins and people who are isolated. The warmline operates 7 days a week from 5-10pm.
- After these Work Training programs, people can move on to competitive employment in the community. Some have moved on to RSS training.

Example: CT Counseling Centers

CT Counseling Centers provide outpatient and IOP services for mental health and substance use as well as running a methadone maintenance program (also starting subuxone soon). 10-12 years ago they realized that the stigma of medication management was a huge problem; patients felt isolated and stigmatized. As a result, they started the MARS and BTR peer programs:

- The **Medication Assisted Recovery Support Services (MARS) program** allows patients to become peer recovery support specialists through a 5-week training. They can then run groups and help engage new patients. MARS was first developed by the National Alliance for Medication-Assisted Recovery (NAMAR). Kurt, Rob Lambert (CEO of CT Counseling) and another patient went to the Bronx for training and came back and replicated the program in South Norwalk. MARS is nationally recognized. MARS has drop-in hours. They also offer family night, holiday gift programs, hikes, trips (e.g., Yankee Stadium), which provide sober social activities.
- As a next step, Rob & Kurt developed the **Bridge to Recovery (BTR) program**, where patients are peer mentors (similar to being a sponsor) and have their own caseload. BTR mentors usually have ~15 cases who are new to the program and feel more comfortable talking to people who share their experience.
- After 2 years when patients are drug free, they can get certified as **Certified Alcohol and Drug Counselors** through the CADAC program offered by CT Counseling. CADAC is a year-long certification program offered on Saturdays (360 hours total). Community members can also take the training. Cost is $2500. Contact CT Counseling to sign up!
- Kurt is now working as a **Recovery Coach** at CT Counseling's Waterbury office, where he provides 1:1 counseling and support. Counselors refer patients who are struggling with their recovery or may be relapsing. Recovery Coach also helps patients during intake with understanding the program.

Other agencies also employ peers in the behavioral health workforce, including two agencies that were unable to attend the forum, which was rescheduled due to snow:

- The Western CT Health Network (WCHN) embeds peers on its **Community Care Teams** at Norwalk Hospital and Danbury Hospital.
- Continuum uses peers in its **community and residential programs**.
- Increasingly, **Community Support Programs (CSP)** and other DMHAS-funded programs have a peer position built into the program contract. CSP is a community-based program that offers case management and skills building to help people live independently in the community.
- With recent DMHAS funding, the CT Community for Addiction Recovery (CCAR) has now placed 10 Recovery Coaches 24/7 in **emergency rooms** at four hospitals in eastern CT. The Recovery Coaches engage people and connect them quickly to a support network that isn't usually available when they

walk out of the emergency room. In the past 8 months the Recovery Coaches have seen 600 people in the ERs and at least half went on to detox or rehab programs.

What is the value of the peer role?

1. "Shared experience" lets peers make genuine, non-clinical connections with clients and motivate them:
    - "I can look at them and tell them with absolute honesty that DBT saved my life and I use it every day and here's how I put the skills into practice every day. It lends a sense of validity to therapy."
    - **"RSS is the embodiment of hope; you are the example of recovery.** Being able to say: I've been there, I will sit next to you is very different from a clinician."
    - "I always tell people they are the best expert on themselves. A lot of our clients have been beaten down and think they have to ask everyone; we try to empower them."
2. Peers help maintain recovery "in more real situations" during "the other 23 hours" a day where a client is not in group:
    - "We see our clients 10-20 hours a week, compared to clinicians who see them a few hours a week, so we know them better. We had a client who ended up in the hospital and the clinician didn't recognize the signs."
    - "The longevity is big, while a brief intervention doesn't usually change someone's life. [This way] you can stay with the person."
3. Clients often share with peers things they do not share with clinicians:
    - "Patients… will tell me things they will not tell their counselors. We can get information from them that they would not generally release to anyone else, and as a team we can help."
    - "[Clients] may feel intimidated sometimes by clinicians, counselors, administrators; it's part of the recovery process. People on methadone have been beat up for so long they have to rebuild themselves as a human being."
4. Peers help with socialization:
    - "They can talk to some peer specialists, have some coffee and vent, bring in their mom and go to Family night."
    - "Patients feel safe, they can speak of their recovery in a safe place, a very positive and comfortable atmosphere. They support each other."

How do agencies see the peer role?

1. Peers play a valuable and cost-efficient role as part of a treatment team:
    - "The peers are at our team meetings every day. Both have their own skill-sets and life experiences but they're Swiss Army knives. They'll speak up and advocate and translate for clients when there's a communication problem. ***There's no challenge that would make an agency not benefit from working with peers."***
    - "The way CT Counseling has integrated the role is great. Patients understand that I do have to report, I'm part of the clinical team meeting every week, no problems with confidentiality."
    - "We can contact supervisors or clinicians directly. We're really engaged."

- "We're relatively cheap labor. What we can produce is so worthwhile. While it doesn't replicate what a clinician does, we can do a lot of what they're already doing. I don't mind saying that I'm cheaper, because I only have a BA, not a Masters. It's a selling point for administrators!"

2. Teamwork is important:
    - "If I can offer guidance through my training and my life experience, I will. If I need help from a more experienced counselor, I will get it."
3. Agencies may have to overcome bias in hiring:
    - "I was always saying peers can work, clients can work, here's the evidence. 5 years of that showed the growth. So when we started hiring peers as state employees, the road was paved. We were seeing people staying healthy and staying in recovery. The majority went full speed ahead, maintained recovery and were competitively employed. People now see the benefit of their work. At first there was some nervousness about relapse."
    - "In meetings with HR, some people were favoring the candidates who had degrees… but we also hired the person without the degree."

Challenges:

1. Agencies differ in recognizing the full potential of a peer specialist position:
    - "If you meet one RSS (Recovery Support Specialist), you've met one RSS. The RSS position is not the same in Bridgeport, Stamford, Waterbury. Originally I wasn't interested in an RSS position because I saw one elsewhere who was a gofer. But here, I'm running a social rehab program."
    - "My former supervisor stood up for us and helped us not become taxi drivers. We still give rides, but it's a ride to be with that person because of some problem they might have, to support them."
2. The peer role in providing recovery support differs from case management and from a therapeutic role:
    - "A case manager would just file the paperwork. As RSS's, we'd go with the client to the library and download the document… It's more time intensive, but the chances they can replicate it in future are much higher. We fill it out together, go to courthouse together. It's much more empowering for the client next time if there's no case manager."
    - "It's a lot of education, not case management. We're more like teachers who walk with the clients. We teach and model and encourage clients so they become independent."
    - "I can walk you through something and I can teach you, but [the therapists] are the ones who can help you process something. As a peer you can get caught up in trying to do therapy work. A co-worker has a situation where therapist and peer work are contradicting each other; so we have to know if we can walk with them, if they should have a peer at that time."
3. There are not enough paid positions for peers:
    - "Before Kurt got this new Recovery Coach position, he was doing everything as a volunteer… Eventually people got paid work and left."
    - "A piece of me is frustrated that funding holds things back."
4. A consumer may have to decide between an employment opportunity and keeping his or her therapy team:
    - "Once someone is employed at SWCMHS, they can no longer receive services there. This can be a challenge for those who may have been with their clinician for years. It can take 6 months to make the transition."

5. Peers are in a vulnerable position, since they are sharing their personal experience rather than maintaining clinical boundaries:
    - Peer: "I see a therapist! Self-care is huge. We have to be trauma informed."
    - Supervisor: "My job is also to maintain the RSS's recovery. I don't want to see you go, I want to see you grow."

What are the next frontiers?

1. Currently, "there is no next level" career path for peer support apart from taking a direct service job:
    - At DMHAS, "the next step up is to be employed as a Mental Health Assistant 1 or 2, but then you're not a RSS any more. MHA 1 is providing direct care on an inpatient unit; you're mandated to do more than just strictly the recovery support piece. I would like to go to a next step, maybe from RSS 1 to RSS 2. Grow the peer support piece!"
    - At CT Counseling Centers, "4 patients [are currently] taking the class to get certified as CADCs because they want to make a career of it. This helps them transition from patient to clinician."
2. Peer positions should be expanded to new program areas:
    - "We hope to see this job expand from one program to another."
    - "CT doesn't have any peer respites. Massachusetts has them (cf. Afiya). [There were times when] I didn't feel safe on my own but I didn't need a higher level of care or hospitalization; I just didn't have a support system." (This is a role for a peer-run respite and would be cheaper than an inpatient stay.)
    - "Peers in the ERs are needed more when someone overdoses. After hours it's very hard to get someone to come in; missed opportunity if have to wait until Monday. Time is a huge factor!" (NOTE: Bridgeport Hospital will soon have Recovery Coaches, and CCAR is also talking to Stamford Hospital about the model.)
3. Funding should be maintained:
    - Social rehab programs and clubhouses that offer support by and for peers are lacking and/or underfunded. The comment that "Clients want places to go, to feel like they're home," has been echoed many times in our region, with consumer groups expressing the need for more places like Bridge House (the clubhouse in Bridgeport).
    - "The Discovery Center in Waterbury was run exclusively by peers but just lost their money."
    - "We can advocate for these programs because we can show that they save dollars" through saving lives in the ER, connecting people with services, keeping people stable in the community and preventing hospitalizations, helping people stay clean and sober.
4. Advocacy with accreditation bodies to build in a requirement for peer employment will make a difference:
    - DMHAS adding in the requirement to its contracts has led to more peers in the workforce.
    - The insurance bill we developed last year that was sponsored by Rep. McCarthy-Vahey to cover peer support services offered in the context of a behavioral health program had a good response from a number of legislators and a lot of support from many in the community. However, any insurance requirement does carry a price tag to municipalities.